

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN3004</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/11/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF GREENEVILLE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>725 CRUM STREET</b> <b>GREENEVILLE, TN 37743</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  An investigation of complaints #TN00054506 and #TN00052288 was conducted 8/10/2021 - 8/11/2021 at Life Care Center of Greeneville. No health deficiencies were cited in relation to the complaints under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE